


INTRAHOSPITAL DEVICES AND CARE PRACTICES: IMPLICATIONS FOR CARE COMPREHENSIVENESS AND CONTINUITY

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ABSTRACT

Objective: To analyze the care production in a public hospital and the devices used for comprehensive care.

Method: This was a health interference study, in which data collection was carried out from September 2019 to June 2022. Observations and field researcher diary records, individual interviews were conducted with coordinators and managers, and focus groups with workers, of a large hospital in Belo Horizonte, Minas Gerais. The empirical material was submitted to thematic content analysis.

Results: Devices that contribute to the construction of new management and care practices were identified. These included the Lean in Emergencies project (Fast Track, Kanban, and Huddles tools); the Internal Regulation Unit; the role of hospitalist physicians, co-managers, and shift coordinators; the work of the home care team within the hospital; and devices for interdisciplinary management, such as interdisciplinary bed runs, case discussions, and shared construction of therapeutic projects.

Conclusion: The implemented devices contribute to the transformation of the health production model and work process in favor of integrating the hospital into the healthcare system.

DESCRIPTORS: Comprehensive health care. Continuity of patient care. Health care models. Hospital restructuring. Community health networks.

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DISPOSITIVOS INTRA-HOSPITALARES E PRÁTICAS ASSISTENCIAIS: IMPLICAÇÕES PARA A INTEGRALIDADE E CONTINUIDADE DO CUIDADO

RESUMO

Objetivo: analisar a produção do cuidado em um hospital público e os dispositivos utilizados para a atenção integral.

Método: trata-se de uma pesquisa de interferência em saúde, em que a coleta de dados foi realizada no período de setembro de 2019 a junho de 2022. Foram realizadas observações e registros em diário de campo do pesquisador, entrevistas individuais com coordenadores e gerentes, e grupos focais com trabalhadores de um hospital de grande porte de Belo Horizonte, Minas Gerais. O material empírico foi submetido à análise de conteúdo temático.

Resultados: foram identificados dispositivos que contribuem para a construção de novas práticas de gestão e cuidado, como o projeto Lean nas Emergências (ferramentas do *Fast Track*, *Kanban* e *Huddles*); o Núcleo Interno de Regulação; a atuação dos médicos hospitalistas, comanejadores e coordenadores de plantão; a atuação da equipe de atenção domiciliar dentro do hospital; e os dispositivos para a gestão interdisciplinar, como as corridas de leitos interprofissionais, discussões de casos e a construção compartilhada dos projetos terapêuticos.

Conclusão: verificou-se que os dispositivos implementados contribuem para a transformação do modo de produção em saúde e do processo de trabalho em favor da integração do hospital ao sistema de saúde.

DESCRITORES: Integralidade em saúde. Continuidade da assistência ao paciente. Modelos de assistência à saúde. Reestruturação hospitalar. Redes comunitárias de saúde.

DISPOSITIVOS INTRAHOSPITALARIOS Y PRÁCTICAS ASISTENCIALES: IMPLICACIONES PARA LA INTEGRALIDAD Y CONTINUIDAD DE LOS CUIDADOS

RESUMEN

Objetivo: Analizar la producción asistencial en un hospital público y los dispositivos utilizados para la atención integral.

Método: Se trata de un estudio de interferencia en la salud que se recogieron datos entre septiembre de 2019 y junio de 2022. Se realizaron observaciones que fueron registradas en el diario de campo del investigador, así como entrevistas individuales con coordinadores y gestores, y grupos focales con trabajadores de un gran hospital de Belo Horizonte, Minas Gerais. El material empírico se sometió a análisis temático de contenido.

Resultados: se identificaron dispositivos que contribuyen a la construcción de nuevas prácticas de gestión y atención, como el proyecto Lean Emergency Care (herramientas Fast Track, Kanban y Huddles); el Centro de Regulación Interna; el trabajo de los médicos hospitalarios, coordinadores y coordinadores de guardia; el trabajo del equipo de atención domiciliar dentro del hospital; y dispositivos de gestión interdisciplinaria, como las carreras interprofesionales de camas, la discusión de casos y la construcción compartida de proyectos terapéuticos.

Conclusión: Se constató que los dispositivos implementados contribuyen a la transformación del modo de producción de salud y del proceso de trabajo a favor de la integración del hospital al sistema de salud.

DESCRITORES: Atención sanitaria integral. Continuidad asistencial. Modelos sanitarios. Reestructuración hospitalaria. Redes comunitarias de salud.

INTRODUCTION

The history of health policies highlights the transformations in hospital institutions that have assumed their current configuration as places for health care¹. Hospitals are no longer seen solely as places for disease diagnosis and treatment but also as powerful spaces for training and technological incorporation². However, within this context, various tensions and disputes arise regarding hospital functioning².

In the hegemonic model of hospital care, professional corporations, especially the medical profession, prevail, with management focused on efficiency, curative and fragmented medical rationality, and the rapid incorporation of technologies that mediate between the caregiver and the user subject.

It becomes, therefore, a challenge to overcome the hospital-centered care model based on biomedical logic, organized in a fragmented and isolated manner, leading to the segmentation of care into specialties and knowledge cores that fail to articulate and share the health needs of users³. Additionally, it is essential to address the challenges of integrating and coordinating hospitals with the healthcare network.

Therefore, it is essential to prioritize the restructuring of hospital care. This restructuring should aim to transform the existing model and practices completely, with a focus on providing care centered on the needs of the users. In order for hospital reform to take place, there are a series of management and care devices and tools that can stimulate this transformation, enhance the use of resources, emphasize interdisciplinary collaboration, and promote network articulation⁴. Several devices for health management and care production have been used and promoted by the Ministry of Health, based on the National Humanization Policy (PNH) and the National Hospital Care Policy (PNHOSP)^{5,6}. Devices are understood not only as strategies and/or technologies, but also as various elements that are interconnected and relate to each other to achieve a certain goal, in this case, the transformation, expansion, and improvement of health care. The device is not static or rigid but dynamic, with a dominant strategic function capable of transforming subjects, relationships, and practices within the work environment¹.

In addition to the aforementioned policies, it is crucial to facilitate encounters and utilize technologies that enable hospital teams to construct more compassionate and inclusive therapeutic projects collaboratively, involving various professionals and healthcare facilities in the network, fostering a horizontal and synergistic approach. This approach reinforces the urgent need for care practices based on comprehensiveness and the provision of safe care transfer between different healthcare facilities^{2,6,7}.

In order to reflect on hospital management and to investigate which devices contribute to comprehensive care within the hospital and connect it more appropriately to the healthcare network, an empirical investigation was proposed in a large hospital in the city of Belo Horizonte, Minas Gerais, Brazil. This article presents the findings of this investigation, which aimed to analyze care production within a public hospital and the devices used for comprehensive care.

METHOD

This was a qualitative study, specifically research-interference in health⁸. Qualitative research considers the historical complexity, context, and implication of the researcher in their relationship with the object under study⁹. Health research-interference is based on the principle of deconstruction, as it questions traditional approaches and produces radical interventions in the field of micropolitics⁹. It seeks to capture the effects produced in the field of study based on the interferences of and with the researcher, capturing the perceived connections and sounds, problematizing the institutional and personal discourse, and producing multiple meanings that go beyond the certainties of hegemonic

science¹⁰. In this type of research, the methodology is constructed throughout the study process, with the researcher attentive to what the field requires^{8,10}. Therefore, this flexible process incorporates different techniques and procedures.

The study was conducted at the Risoleta Tolentino Neves Hospital (HRTN), a large public general hospital located in the municipality of Belo Horizonte, in the state of Minas Gerais. The hospital has approximately 400 beds, including a 24-hour emergency department, a maternity ward, and a unit for the care of respiratory symptomatic patients from 2019 to 2022, during the COVID-19 pandemic. It exclusively serves users of the Brazilian National Health System (*Sistema Único de Saúde - SUS*) and is a reference for approximately 1.5 million people in the northern portion of the metropolitan region of Belo Horizonte. It is also a teaching hospital and a field of practice for a federal public university^{11,12}.

The institutional model encompasses the integration of care, management, education, and research, forming a comprehensive approach. It is structured around four Lines of Care (LC): clinical, surgical, maternal-child, and intensive, defined according to the health needs of the population in the coverage area¹¹.

The study that originated this manuscript had its fieldwork conducted from September 2019 to June 2022, during which various interferences were carried out with the actors in the field under study. Prior to the fieldwork, an integrative literature review was conducted on care continuity and comprehensiveness, identifying devices used for this construction within the hospital.

The integrative review was conducted from April to May 2021, resulting in 139 publications. The inclusion criteria defined for all databases were: being in Portuguese, English, or Spanish; published in the previous ten years; and containing in the title, abstract, or keywords the following Health Sciences Descriptors (DeCS): Integrality in Health, *Integralidad en Salud*, *Integralidade em Saúde*; Healthcare Models, *Modelos de Atención de Salud*, *Modelos de Assistência à Saúde*; Hospital Admissions Department, *Servicio de Admisión en Hospital*, *Serviço Hospitalar de Admissão de Pacientes*. In addition, the keywords "Healthcare Networks" and "Hospital" were included, with the options AND and OR, respectively. The review identified intra-hospital devices, assuming organizational and relational practices to achieve comprehensive care in hospitals of Brazil and other countries¹³.

Data collection was carried out using different techniques: individual interviews with semi-structured scripts, focus groups, observation, and researcher diary record.

The first phase of the study involved immersion in the institution to understand the local reality and context. During this phase, observations were conducted on the daily work of the healthcare providers, coordinators, and managers, as well as on the meetings of management committees. The focus was also on nursing and other care activities within the different lines of care, continuing education actions implemented within the hospital, emergency department care, and patient rounds in the inpatient units. These rounds served as an opportunity for multidisciplinary case discussions and collaborative development of the therapeutic project, involving the various professionals meeting at the patient's bedside.

Subsequently, additional visits to the hospital were made over the following three years for data collection, totaling approximately 40 pages of description in the researcher's field diary, consisting of records and notes of experiences, including events, impressions, and reports of how participants' relationships were formed in their daily lives.

In the second phase of the study, 13 in-depth interviews were conducted by the principal researcher with hospital managers and coordinators, selected because they are drivers and coordinators of the care management within the hospital. The interviews were conducted in the hospital itself and guided by a semi-structured script with questions that sought to capture the interviewee's perception regarding interdisciplinary work, care production, intra-hospital devices used, and the relationship with the healthcare network.

Two focus groups were also conducted on different shifts with hospital workers, with the purpose of bringing their perceptions and concepts about the study topic. Approximately 15 participants representing all professional categories working in the hospital's lines of care were invited to each group. A total of 22 healthcare providers, including physiotherapists, nurses, nursing technicians, physicians, social workers, psychologists, speech therapists, nutritionists, pharmacists, administrative assistants, and radiologists, participated in the focus groups.

Participation in the focus groups was open to all professionals in the lines of care. In cases where a category did not participate, a professional suggested by the line's coordination was invited. The focus groups had a script with provocative questions about interdisciplinary work, the facilitators and challenges of care production, and the devices that professionals use to promote comprehensive care. To stimulate discussion, a problematic situation was presented regarding a patient with an acute stroke. This situation was identified during the observation phase, representing common recurrences in the hospital. This exercise allowed the healthcare providers to reflect on their own work, considering the world of care as a place to operate devices and produce networks of connections³.

The interviews and focus groups were audio-recorded, totaling six hours and two hours and 15 minutes of recording, with an average duration of 30 minutes for the interviews and one hour for the focus groups. Subsequently, the recordings were transcribed by the researcher.

In the presentation of the results, excerpts from the interviewees/focus groups' statements were identified as follows: Interview_Ind from E01 to E13 for individual interviews, and FG1 or FG2 for focus groups one or two, respectively, followed by the professional category and the numbering from 01 for the first professional in that category to participate, and so on. The researcher's observation narratives were identified as "researcher's field diary", followed by the date of the event.

It should be emphasized that this work was influenced by the COVID-19 pandemic, which made it impossible to access the field for a significant part of the time, causing delays but without significantly affecting the study.

In the data analysis process, the researcher immersed herself in each transcription and field diary writing, through thorough reading of the material, highlighting and categorizing the contents that addressed the research questions. The entire data analysis process followed the thematic content analysis technique⁹. Theoretical references on comprehensiveness and care production, as well as studies found in the integrative review conducted as an initial stage of the investigation, were used to discuss the data¹³.

The project was approved by the Research Ethics Committees of the Federal University of Minas Gerais, the Municipal Health Department of Belo Horizonte, and the participating hospital. All participants signed a consent form, following Resolution nº 466/12 guidelines.

RESULTS

The study consisted of 35 participants, with 13 of them being coordinators or managers who were individually interviewed, and 22 who participated in the two focus groups conducted. Regarding professional category, participants were eight nurses (22.9%), seven physicians (20.0%), three psychologists (8.6%), three physiotherapists (8.6%), three social workers (8.6%), two representatives (5.7%) from each of the following categories: speech therapist, administrative assistant, nutritionist, nursing technician, and occupational therapist, and one radiology technician (2.9%). Of the 35 participants, 62.9% represented healthcare providers, 25.7% held coordination or management positions, 5.7% assumed some technical reference roles, 2.9% were from the board of directors, and 2.9% were director's advisors.

In the process of building an integrated and interdisciplinary care model, the hospital has been implementing devices that have contributed to the development of new management and care practices, as well as the restructuring of the way daily work is executed. Among the care management devices, the participants emphasized the Lean Project in the Emergency Departments with the tools of Fast Track, Kanban, and institutional and sectoral Huddles; the Internal Regulation Unit (IRU); the role of hospitalist physicians, co-managers, and emergency department coordinators; the role of home care teams from the municipal health department within the hospital; and the devices focused on the management of the work process, such as multidisciplinary patient rounds, case discussions, shared construction of therapeutic projects, preparation of family caregivers, and responsible referrals to the SUS network of Belo Horizonte and surrounding municipalities.

Lean Project in the Emergency Departments and its tools

The Lean Project in the Emergency Departments was developed with the support of the Ministry of Health and is part of the Institutional Development Support Program of the National Health System (PROADI-SUS), under the coordination of the Hospital Sírio Libanês. The project consists of several tools to improve emergency performance, including Kanban, Fast Track, Huddles, Medical Decision Unit (MDU), Short Stay Unit (SSU), and Full Capacity Plan (FCP).

From management to technical staff, cleaning... the entire team here at Risoleta is aligned with a single purpose, which is patient care, and the changes proposed by the sector are certainly aimed at fulfilling the patient's needs, just like when we say, 'let's do a Huddle, a Kanban'. (FG1_Nurse_01).

[...] he (nurse) was talking about when the Fast Track or Lean Project started. The proposal was to reduce waiting time and speed up emergency care and, as a result, the turnover of beds in the emergency department and units [...] you accelerate, in quotes, the care for this patient and optimize the organization of the entire emergency department's functioning [...] with overcrowding at the entrance, and often a reflection of what the city is going through at the moment, whether it's a dengue outbreak, influenza, COVID, or even a multiplicity of causes, the waiting area gets filled, the corridors get filled, and the hospital gets overwhelmed [...] the idea is not to lose the 'efficiency of the ER, it is to make it rotate with quality and safety'. (Researcher's Field Diary - January 14, 2020).

The focus of improvement could be seen in the emergency department care, made possible through the implementation of boarding (patients waiting for inpatient beds) and the Full Capacity Plan (FCP), which supports better bed management in the hospital, reducing overcrowding problems and poor staff distribution in the workplaces. In addition to highlighting the project itself, the participants emphasized the effectiveness of specific Kanban and Huddle devices in improving the quality of patient care by reducing waiting times and increasing efficiency.

When implementing Kanban, the team is aiming for the strategic change of internal decision-making in the hospital, seeking to identify the true problems that delay patient care and follow-up.

Kanban came to help a little, other tools as well [...] are clinical management tools that were missing, today it is quite visible (Interview_Ind_E01).

We, as a team, can further advance the organization of work and quality of care at Risoleta using Lean strategies. And to achieve good results, we need the involvement of all workers. (Interview_Ind_E09).

Now we can see that this is a tool that is helping us, we can see what is holding the patient here and act more quickly. (FG1_Nurse_02).

Other significant strategies of the project, still in the implementation phase, are the Short Stay Unit (SSU) and the Medical Decision Unit (MDU). The SSU provides special care for patients with an average three-day hospital stay, allowing better bed turnover and more appropriate care for these patients. The MDU establishes a careful clinical assessment, defining the quickest destination for the patient within the hospital.

Internal Regulation Unit (IRU)

The IRU was mentioned by several participants as a device that brought together the hospital teams, establishing a dedicated space for coordinating care and managing beds more efficiently within the hospital. For the functioning of the IRU at HRTN, the team consists of a coordinating nurse, another nurse with 24-hour coverage, supported by an administrative team and the emergency department's on-call physician coordinator. This arrangement of professionals guides the micro-regulation of beds within and outside the hospital (linked to the central regulation centers of Belo Horizonte and surrounding municipalities), establishing rules to expedite and reorganize patient care in the emergency department and inpatient units, as well as their referencing or referral when necessary.

The internal regulation unit of the hospital manages not only the beds as a resource but is also a strategic point for managing patient care, especially by preparing for discharge together with the teams. The IRU has raised the possibility of establishing a counterflow with the network. (Interview_Ind_E01).

Hospitalist physicians, co-managing physicians, and emergency department coordinators

Other strategies mentioned by the participants refer to investment in horizontal care through hospitalist physicians (those who work on a daily basis from Monday to Friday), co-managers who are clinical physicians responsible for co-managing patient care in both the emergency department and the inpatient units, and emergency department coordinators. Hospitalist physicians, due to their daily and horizontal involvement (rather than working in shifts), monitor daily care plans and shared therapeutic projects, coordinating care and managing the cases of these patients, as well as orchestrating the construction of therapeutic strategies and comprehensive care through lines of care within the hospital.

The hospitalist physician moderates the patient rounds; they have known this patient since they were in the emergency department because they have been participating in these rounds. And this transition is done very carefully because we already have a construction of this patient's demands, a design of their therapeutic plan, and this is handed over to be continued on the ward. (Interview_Ind_E08).

The emergency department's on-call physician coordinator is a representative of the board, of the institution [...] when the nursing coordination of the IRU is not here, they are the person who will manage the clinic, the general area, orthopedics, the surgical block, ICU beds, regular ward beds [...] they are the ones who will liaise with all areas. (Interview_Ind_E01).

This care transition, for example, to the intensive care unit, is done by the co-managing physician. This is very specific here in the hospital because, usually, it's a patient who has been admitted for a short time, and their history is not always clear yet, or if it is clear, it still requires other more specific information, and the physician handles this transition of care to the ICU in place. (Interview_Ind_E10).

Multidisciplinary Home Care Team (MHCT)

The participants revealed the Multidisciplinary Home Care Team as one of the main devices responsible for legitimizing and ensuring continuity of care in the SUS health care network.

The hospital management, together with the Municipal Health Department, implemented two multidisciplinary home care teams within the hospital. This model allows daily discussion with the care teams through interdisciplinary patient rounds, guiding the other team members, the family, and the patient regarding safe discharge and shared post-discharge care in the patient's territory and home. (Researcher's Field Diary - August 16, 2021).

With the expansion of the MHCTs, which are the home care teams, we can create a better bridge between the hospital and other points of care in the network through home follow-up. (FG1_Nurse_02).

Complementary to the MHCT, procedures were mentioned that support the work process of the teams, ensuring the continuity of care without obstacles for the patient. Examples of these procedures include sequential oral and intravenous treatments at home or in municipal hospitals in the surrounding area and scheduled discharges with meetings involving the patient's family or teams in the network.

Now, from the perspective of external tools, which end up being internal for the external, today we have the issue of sequential oral treatment (SOT). When a patient needs to use antibiotics but can continue the treatment at home, the hospital provides this antibiotic for the patient to finish the treatment at home today. (Interview_Ind_E09).

All our discharges are scheduled discharges; we always communicate with the family one day before, and in palliative care, we take even more care. We have a meeting with the network teams before the discharge because these patients come with a poor prognosis, even if we already know it, and we are there to control the symptoms. (Interview_Ind_E04).

Devices focused on the management of the work processes

The hospital, in its mode of operation, incorporates several devices that strengthen the management of the work processes, present in interdisciplinary practices, live and active work, and the organization of the work processes. One way to operationalize these mechanisms is by strengthening the interdisciplinary team through systematic meetings, active search routines, patient rounds, case discussions, communication via WhatsApp®, and assertive communication through medical records, with users and their families, among others.

Even during the active search, that's when I see a lot happening. Sometimes, even before we think about requesting a consultation, someone from another discipline has already gone there and evaluated the patient. (FG1_Physician_01).

Nowadays, there are weekly meetings with the interdisciplinary team in the medical and surgical units. These meetings are very enriching moments because they allow for the discussion of profiles and the definition of referrals, considering the safe discharge of the patient. (Interview_Ind_E05).

And then there's communication via WhatsApp®, there's team meetings; we meet as a team, and we have a weekly meeting with our team. (FG2_Occupational Therapist_01).

DISCUSSION

The hospital, as a complex institution, increasingly presents emerging challenges, such as the growing rationalization of medical-hospital practices, which tend, for example, towards specialization and the prioritization of technology¹⁴. While public and private hospitals are increasingly aligned with global economic activities and receptive to cost-effectiveness evaluation, there is also a need to invest in strategies that address the consequences of this growing specialization in clinical practice^{2,15}.

In this sense, addressing the fragmentation of hospital care requires understanding and action from the institution's management and healthcare workers towards a new care model for the hospital. HRTN has managed to implement the devices mentioned, aiming for a more shared care project. It is not possible to break the hegemonic medical paradigm perpetuated in traditional hospitals without an internal alignment capable of establishing multidisciplinary and shared practices in daily routines.

The devices implemented in HRTN shape the restructuring of hospital care, as they contribute to a new rationality in both management and care logic. If only tools are employed to impact the rationality of management without effecting real transformations in the care practices, they become strategies limited to cost reduction and administrative-bureaucratic aspects of management. This is not effective for transforming management and care models within the hospital.

The Lean in the Emergency Departments Project has been increasingly incorporated into healthcare institutions as it proposes discussions with workers on team, autonomy in decision-making and the incorporation of tools that strengthen quality and safety in care, reducing costs and process time¹⁶.

The implementation of the Internal Regulation Unit (IRU) is guided by the strategy for organizing the hospital component of the Health Care Network (RAS). The IRU was consolidated based on the National Hospital Care Policy under the National Health System (SUS) and has since been a strategy for organizing access to consultations and diagnostic and therapeutic services, as well as defining the availability of hospital beds⁶.

Through the participants' statements and observations made, it was identified that the IRU has facilitated care management within the hospital, improving internal communication with all departments and aiming for agility and safety in patient transitions between care units. The success of the IRU in the hospital is partly due to the support of the management in reinforcing its role in coordinating the entire regulatory process and the significant interaction of the unit with other devices implemented. It is worth highlighting the IRU's articulation with Institutional and Sectorial Huddles, Kanban, Fast Track, the Emergency Department, and inpatient units, as well as with the entire hospital through closer and more efficient communication with support units such as the ombudsman, sanitation and cleaning, and social services, among others. By participating and interacting collectively, for example, in Institutional Huddles held three times a day (at 9 am, 3 pm, and 9 pm), these units coordinate and strengthen the internal and external regulation capacity of the IRU.

One of the strategies that optimized greater internal communication was the incorporation of co-managing physicians, who are responsible for facilitating conversation and coordination with the care teams during care transitions, co-managing the patient's therapeutic plan^{17,18}. In addition, the participation of horizontal physicians in all care units within the hospital ensures better case management and care in daily services. The coordination between the on-call physician in the emergency department and the IRU has created a differentiated dynamic for internal and external regulatory processes and strategic care management within the hospital.

These experiences have been witnessed in other institutions and constitute an innovation in hospital care, including care horizontalization, expanded clinical support, and improved flow and patient follow-up, providing greater support for care transitions. These interventions have shown better

results in indicators such as length of stay, occupancy rate, average number of hospitalized patients, and overall hospital production, as well as improvements in care quality within the hospital^{13,18}.

Additionally, there are devices aimed at improving work process management, such as multidisciplinary meetings, patient rounds, clinical case discussions, and various other daily tools for interdisciplinary coordination and the sharing of more caring therapeutic projects for users. The use of these devices is important for the development of health actions, guiding care, reflecting reality, and acting as care production enhancers¹⁹. Furthermore, the chosen path for the studied hospital was to amplify a management approach based on democratization and participation. Decentralizing decisions is another factor that can strengthen and enhance the success of devices implemented, contributing to the transformation of the traditional, highly centralized hospital^{2,4}.

The realization of this internal integration and coordination, along with a decentralized approach and vision, results in benefits, particularly in the relationship the hospital establishes with patients, as it allows for greater user and family participation in the decision-making process regarding their therapeutic projects. This is a differential for this model of shared decision-making²⁰. Other studies have reported the connection of these devices with the practice of expanded clinical care, subject-centered care, and/or clinic management as ways to promote care, based on the involvement of individuals in their own issues and aligned with their needs^{13,21}.

In this context, in order to expand care possibilities for patients with chronic diseases, some countries have invested in telemonitoring technologies as devices to improve clinical effectiveness and territorial tracking of these patients by the care team^{22,23}.

Recognizing the various devices for care production, home care has proven to be a relevant possibility for innovating health production^{13,25}. The existence of MHCT teams within the studied hospital provides an opportunity to articulate and integrate the hospital with the service network, creating the capacity to manage patient entry and exit itineraries within the complexity of the network. When properly implemented and aligned with the establishment of safe discharge practices, it reduces the challenges of excessive utilization or the absence of care destinations that ensure safe and adequate patient care^{2,24,25}.

It is essential to emphasize that beyond implementing devices for improved healthcare management and institutional performance, there is a critical need for discussions on the meaning of care and the identity of the individuals who require care. Governance and management processes centered on quality and the user present good results when committed to providing comprehensive and shared care, both with care teams and with users and their families^{25,26}.

The hospital can be seen as a structuring component to foster comprehensive care, considering the principle of comprehensiveness^{2,26}. It is a "care station" that individuals pass through to obtain comprehensiveness in health. However, in order for this premise to be achieved, devices that connect the hospital more effectively to the service network must be considered because, as excellent and specialized as it may be, the hospital alone cannot guarantee comprehensiveness; it can only do so if effectively integrated into the network.

In the hospital context, achieving comprehensive care requires reevaluating and transforming the caregiving dimension, which can be accomplished by integrating devices and health technologies. By appropriating these devices, professionals can enhance their capacity to provide care by balancing instrumental and communicative rationality with the perception of the individual as a real being and protagonist of their own health-disease process²⁷.

FINAL CONSIDERATIONS

The findings demonstrate progress in the construction of a new care model and practices within the hospital and the contribution of implemented care management devices. Therefore, it can be stated that comprehensive care integrated into the network is a possible practice, however, depends on how the hospital incorporates existing knowledge, technologies, and new healthcare models and management approaches that go beyond the hegemonic centralizing and rationalizing dimension established in hospital institutions.

Furthermore, for the hospital, as a care station, to become an interconnected facility with different health services in the network, the institution's workers and management need to be aligned with the principles that support a user-centered, interdisciplinary, and comprehensive care model. They should be oriented towards practical integration and coordination. Otherwise, there will be no overcoming of the hegemonic hospital-centric model or transformation in the hospital's daily practices.

Lastly, as a limiting factor, although this study encountered common problems and challenges faced by contemporary hospitals, it is important to note that it was conducted in only one hospital with specific and unique local context and characteristics. Therefore, its findings cannot be extrapolated or reflect the reality of all hospital institutions.

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NOTES

ORIGIN OF THE ARTICLE

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